

VOLUME 5  
REPORT NO.1

DOCUMENT SECTION

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# MONTHLY HEALTH REPORT

U.S. Army.  
Military District of Washington

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AUTH FO 10501

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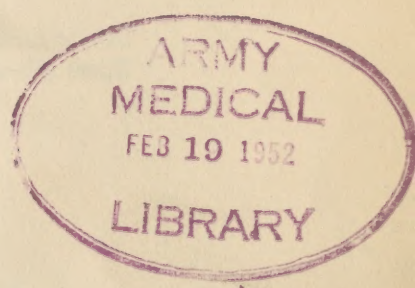
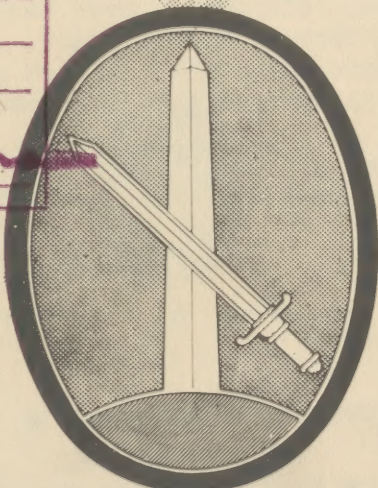
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JANUARY 1952





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This "Monthly Health Bulletin" invites every reader to participate in its preparation by contributing articles. There must be something in the daily military experiences that will interest others and possibly be helpful to others. Administrative directives, professional articles, clinical notes, descriptions of new devices and instruments are welcomed. While the number of copies of this publication is not great, there is a wide distribution, geographically speaking.

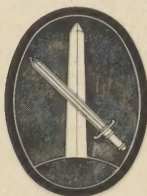
Contributions should be addressed to The Surgeon, MDW, Room 2D-201, The Pentagon, Washington 25, D. C.



MAJOR GENERAL THOMAS W. HERREN  
COMMANDING  
MILITARY DISTRICT OF WASHINGTON  
Room 1543, Building T-7, Gravelly Point  
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## INTRODUCTION

This publication presents periodic health data concerning personnel of the Department of the Army in the Military District of Washington. It provides factual information for measurement of increase or decrease in the frequency of disease and injury occurring at each of the posts, camps or stations shown herein.

It is published monthly by the Military District of Washington for the purpose of conveying to personnel in the field current information on the health of the various military installations in this area and on matters of administrative and technical interest. Items published herein do not modify or rescind official directives, nor will they be used as a basis for requisitioning supplies or equipment.

Contributions; as well as suggested topics for discussion, are solicited from Army Medical Service personnel in the field.

ROBERT E. BITNER  
Colonel, MC  
Surgeon



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## PREVENTIVE MEDICINE

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### PROGRESS IN ARMY TROPICAL DISEASE RESEARCH SINCE MAJOR WALTER REED

By

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Brigadier General, U.S. Army (Retired)  
Dean and Professor of Public Health  
Harvard School of Public Health

I am naturally glad to talk about the progress which has been made by the U. S. Army in its researches on tropical diseases since the time of Major Walter Reed; because the story of the Army's contributions in this important field is a romantic tale of high adventure and great scientific service which has brought new hope to the disease-ridden peoples of the entire world.

Since the beginning of time, military leaders have recognized the need for procedures with which to prevent disease among their troops. Because of this long recognized importance of disease, it was natural that our medical officers of the last century accepted the early developments which brought us the first exact knowledge concerning the etiology of infectious diseases as an opportunity to apply this knowledge for the protection of troops.

During the period 1893 to 1902, the Medical Corps was fortunate in having as its Surgeon General, a great scientist (George M. Sternberg) who was in reality the father of preventive medicine in our Army.

At the time of the Spanish-American War the new science of bacteriology had been born, but we knew little about the epidemiology of many of the infectious diseases.

General Sternberg did everything in his power to stimulate and strengthen medical research.

In November 1951, we celebrated the 100th Anniversary of the birth of Walter Reed, who was President of the Board which General Sternberg sent to Cuba to study yellow fever. We are all familiar with the results of that brilliant program of investigation. Walter Reed confirmed the hypothesis of the Cuban physician, Carlos Finlay, that yellow fever is transmitted by *Aedes* mosquitoes. He also proved for the first time that yellow fever is caused by a filtrable virus. This single contribution of our Army stimulated the extensive researches, which have given us an effective vaccine now used to protect American troops against this disease.

Colonel Richard Pearson Strong, then a First Lieutenant of the U. S. Army. We discovered the Strong Dysentery Bacillus, and investigated plague, cholera, and various other diseases of warm climates.

Col. Bailey K. Ashford investigated a severe disease then known as malignant Puerto Rican anemia, and showed that it was due to massive hookworm infection. This work led to the world-wide campaign of The Rockefeller Foundation for the control of hookworm in many countries.

Colonel Charles F. Craigh did distinguished pioneer work on Dengue Fever, amebiasis and malaria. Later Colonel Joseph Siler and others continued to develop our basic knowledge of dengue. In the Army Medical School, in these overseas locations, and later in Panama, medical officers carried forward the researches stimulated by General Sternberg. Well-known results are the development of the Army's highly-effective triple typhoid vaccine by General F. F. Russell, and General Darnall's contribution which gave us the basic principles now used by all great cities of the world for the chlorination of their water supplies. General Raymond Kelser demonstrated for the first time the mosquito transmission of equine encephalomyelitis.

However, the total amount of research that could have been done by the Army in peacetime was restricted by lack of interest and inadequate appropriations from our Congress. The Medical Corps recognized the need for more knowledge in order to meet the hazards of an all-out war fought in the tropics. But this unfortunate deficiency in our research program was not corrected until the beginning of World War II.

The war-time research carried on in the Army under the direction and supervision of the Surgeon General covered such a wide range of subjects that I shall not attempt to enumerate them. The contributions of the Army Epidemiological Board during the war constitute a great service to the



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## PREVENTIVE MEDICINE

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future of military preventive medicine.

Another important research group also organized by the Preventive Medicine Service, was the U.S.A. Typhus Commission. It functioned as a joint Army-Navy-Public Health Service organization to study epidemic typhus in the laboratory and the field. Its purpose was to prevent typhus in allied troops and also to prevent a recurrence of the disastrous spread of typhus fever which followed World War I.

Two other organizations of enormous help to the Army's war-time research program were the National Research Council and the Office of Scientific Research and Development.

Results of all these research activities have freed us from the fear of certain tropical diseases which had enslaved mankind since the beginning of time. For example, our Army is no longer afraid of the crippling action of epidemic louse borne typhus because our troops now have an effective vaccine and an even more effective DDT louse powder. We are no longer afraid to expose troops to yellow fever in the jungles of South America or Central Africa because we now have an effective vaccine. Our war-time researches have given us effective suppressive drugs with which we can protect fighting troops in the worst malarious areas of the world. We are armed with chloroquin for suppressive use, and we now have effective new drugs with which we can cure clinical attacks of malaria. Equally important is the development of our new insecticides and repellents.

As planned during the war, a vigorous program of peacetime research has been continued at the Army Medical School, and in our various Army laboratories in this country and abroad. From the Army Medical School, Dr. Joseph Smadel and his co-workers have been conducting field researches in the Dutch East Indies which have given us new methods for the protection of troops against Scrub Typhus, and as a by-product, have uncovered for the first time a specific cure for clinical typhoid fever.

All of these intelligent activities are aimed at increasing our basic knowledge about the prevention of military diseases. They have the direct objective of learning how to prevent disease under military situations in order to keep the well soldier well. This type of research is the very essence of sound military preventive medicine. It is not something that can be done only by laboratory experts; it is the responsibility of every medical officer in our Army. When he enters military service, the physician accepts a serious responsibility. He - and he alone - is able to advise commanding officers properly as to what action should be taken to protect the lives and the health of his men from preventable disease and injury. Therefore, in order to perform his job properly he cannot limit his concern to the salvage of the sick and wounded, but he must keep in mind at all times his greater obligation which is to keep the soldier well and fit to fight.

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### MEDICAL CERTIFICATION OF CAUSES OF DEATH

Attention of commanders of Army medical treatment facilities in the continental United States, Alaska, Hawaii, and Puerto Rico is directed to a film strip and record on the medical certification of causes of death, prepared by the National Office of Vital Statistics, Public Health Service, Federal Security Agency. The film strip and record have been made available by the Federal Security Agency to the various State and territorial health departments.

The preparation of this film strip was undertaken by the National Office of Vital Statistics in an effort to improve the medical certification of causes of death in the United States and Territories. The film strip presents an excellent pictorial discussion of the fundamental principles underlying the proper recording of causes of death on death certificates, particularly in cases involving multiple causes. The National Office of Vital Statistics has requested the State medical treatment facilities by expanding the coverage in the showing of the film strip. In view of the importance of this effort, all commanders of Army and Puerto Rico are urged to contact the appropriate State or territorial health department and arrange for a showing of the film strip to the medical officers of the medical treatment facility.

(This above is form Dept. of the Army Circular No. 46, dated 12 June 1951.)



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# ADMINISTRATIVE SERVICE

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## VENEREAL DISEASE INTERVIEWING

Adapted from an article by:  
J. GEORGE FREDERICK  
Published by The Business Bowse

The patient's "no" must never be taken as final!

The study of different kinds of "no" and their meaning is a study of human relationships. Each "no" acts to initiate a series of ideas in the person conducting the VD contact interview.

A list of 25 important "no's" and the answer to meet each one, revamped to fit conditions of the VD patient interview and re-interview is presented below:

1. The Ignorance "No." All ignorance, lack of knowledge, lack of awareness, lack of information rouses fears. All fears generate negativity, repression, drawing back. Ignorance is the worst enemy of contact-naming. Ignorance indicates the presence of poor approach by the person conducting the interview, and sluggish interview technique. The ignorance "no" is best removed by seriously, determinedly applied knowledge.
2. The Loyalty "No." The patient has mistaken ideas of loyalty, faithfulness and constancy to those with whom exposure has taken place. Persistence, diplomacy and clear logic are required to overcome the loyalty "no" and to cause the patient to change on new analysis of the situation.
3. The Rationalizing "No." The patient has made up his mind long in advance. He has sufficient reasons to say nothing. He "knows" disclosure will do good to nobody. It's idle to attempt a rational approach to the rationalizing "no." An emotional appeal is best.
4. The Challenging "No." The patient wants to be shown. He has his own ideas but will change if the interviewer accepts the invitation to a contest and gives plenty of good factual material and astute arguments. Sometimes the challenging "no" is only the desire for a good argument. Show me!
5. The Procrastinating "No." The patient has the habit of postponing action, tomorrow or day after tomorrow, but not now. The interviewer must force by indicating its advisability and the costliness of delay. Why not now!
6. The Timidity "No." Many patients lack courage or self-confidence to expose their own individual sexual experience to any one and in particular to the person conducting the interview at the moment. The need here is for the interviewer to inspire courage or to transfer the patient to an interviewer of the opposite sex or of another mode of approach--all in the patient's interest.
7. The Mistaken "No." Patients say "no" before they think. Then because of the mistaken "no," the ill-digested, poorly conceived reason for "no" cannot be changed without clever, able interviewing. Above all else, save face for the patient! Do not exult if the patient's "no" is changed to "yes." Reduce your own personal pride, charmingly accept as a pleasure the change in the patient from the mistaken "no" to "yes."
8. The Unhappy "No." The patient must say "no" because the cup of wretchedness is overflowing. The unhappy "no" may be reversible. A new angle of approach by the interviewer may develop mutual sympathy. Special aid, special ingenuity, special generosity on the part of the interviewer may create a situation favorable to naming contacts.



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9. The Impatience "No." Quick temper, restlessness, hasty irascible temperament produced premature, impatient "no." Watch for it! Guard against it by avoiding a weak approach and wordy argument. The impatience "no" requires diplomacy, graciousness, cool temper, clear concise arguments to change "no" to "yes."
10. The Indecisive "No." Vacillating patients are constitutionally unable to decide anything, to reach any conclusion. The interviewer must supply mental and emotional assistance to bring the patient to a decision. The interviewer must supply a "clincher." It's not easy.
11. This Discomfort "No." The patient is disturbed, uneasy and distressed. The situation is just no good. Judgment was misplaced. How else is it possible to explain the present predicament? Physical conditions of the conference are not so good. The desk is exposed to view. The questioner is a female. The chair is too high or too low. The patient feels it is proper to be irritated, upset and nervous. Certainly sickness is discomfort by itself. Add the depression of discovery, the pessimistic outlook, the worry of explanation. Everything adds to discomfort "no." How to overcome the discomfort "no?" Put yourself in the other fellow's place and create an atmosphere to dissipate the discomfort.
12. The Arbitrary "No." Because of caprice, some patients give an arbitrary "no." Argument does not help; in fact, it hinders. There's only one thing to do. Change the interviewer at the time or recapture the patient at a subsequent visit.
13. The Flippant "No." The quick trigger "no"--not serious, not studies, just "no." The interviewer must recognize the character of the person behind the flippant "no," seek "pay dirt" and acquire names by competently reviewing the facts.
14. The Indifference "No." The apathetic patient figures he "got" his... why bother about anyone else? Here is a high measure of indifference, imperviousness. The patient is armor-plated. He resists each and any logical effort. The indifference "no" can be broken mainly by jolts, in a startling, arresting manner, to selfinterest.
15. The Fearsome "No." The frightened, fear-ridden patient faces the immediate future with pessimism, lack of confidence. The patient fears the worst. The "no" is a shivering "no," a jittery "no." The cure is transfer of confidence the interviewer must have to the patient. The fearsome "no" dissolves with the loss of fear.
16. The Show-Off "No." Some patients are ostentatious. Despite the evidence of their disability, they bluster, preen themselves and show their authority over themselves and the interviewer by the show-off "no." There's only one way to beat it. Go it one better and feed the expanded ego. Accept the superior vanity and overestimate the number of names the patient is capable of giving.
17. The Time-Pressure "no." Patients are in a hurry or think they are. It is important to be in a hurry. Time-pressure "no" may be legitimate--the driver has the vehicle outside or his car is doubleparked. But the time-pressure "no" may just come. The interviewer must concentrate on simple argument, fast delivery, incisive separated appeals and, above all, a calm manner.
18. The Inferiority "No." Too many of our patients feel defeated, doubt their own ability, dread their own ineptness. To be safe, to be on the defensive, they give the inferiority "no," sometimes with exaggerated aggressiveness.



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## ADMINISTRATIVE SERVICE

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The interviewer has the task of recognizing the inferiority "no" for what it is and then of proceeding to build confidence and extract the desired information.

19. The Stubbornness "No." Just don't push me around. Because you thought you could push me around even if you didn't. If the patient feels this way, his answer is the stubbornness "no." The patient is obstinate, unyielding and will not give you satisfaction. You develop nothing. The interviewer must not force any issue. He must let the stubborn "no" patient win or appear to win. He must not mention pighead or mule. Sometimes the ice of stubbornness melts. Usually, it requires a new interviewer, a new time, a new approach and new knowledge imparted to the patient.
20. The Financial "no." The financial "no" comes from the male patients who insist they never paid for female companionship, for favors. Hence, they do not divulge names and addresses of contacts paid with money. Nearly all men deny the idea they were paid but certainly they never paid. The clever interviewer forgets all financial considerations and even the very existence of money in conversation with patients during the interview involving the financial "no."
21. The Performance "No." The patient is a repeater. He has gone through all this before. His idea is that it didn't work before and it won't work now--why give names and addresses? The performance "no" is tough for the interviewer. It is necessary to regain confidence, to probe gently, to teach.
22. The Bluffer "No." It is very difficult to determine the reason why a patient just sits and denies the facts of life to you and apparently to himself. He is bluffing. His bluffing is a hope. The entire business will just cease to exist. It just didn't happen. The interviewer must analyze the situation and dig deeply and diplomatically. No one method helps. Success depends upon youth of the patient, his sex, domination by parents, older or wiser schoolmates, etc.
23. The Vindictive "No." This is just the result of prejudice on the part of patient at that crucial moment. He doesn't like the sex, color, age or clothing of the interviewer. He doesn't like the idea of being in the situation he finds himself. He will avenge!
24. The Weaselword "No." Just a smokescreen, meaningless, sort of can't place the "no" in any other category. Here is the exception, the freak, the biologic sport, the out-of-this-world character, but he says "no" just the same.
25. The Authentic "no." The authentic "no" never exists in social hygiene conference room work. The evidence is there. The infection came from a human being and was transmitted to another human being. The patient knows. Your job is to have him tell.

### HOSPITAL FUND ACCOUNTING FOR PAY PATIENTS

Excerpts from SR 40-650-1.

"Charge will be made for the day of admission, regardless of the how; no charge will be made for the day of discharge. Departure of paying patients on authorized leave or pass, as shown on the admission and disposition sheet, will be considered as a day of discharge. Return of paying patients from authorized leave or pass, as shown on the admission and disposition sheet, will be considered a day of admission."



### TULAREMIA

by

Captain Larry E. McClaghry, V. C.  
Assistant to Veterinarian  
Military District of Washington

Tularemia is primarily a disease of rodents, especially wild rabbits, and is capable of causing infection in man. The causative organism is *pasteurella Tularensis*. The disease Tularemia, as it is now called, was recognized in 1910 and was named "plague like disease of rodents" and "deer fly fever" and rabbit fever. McCoy, due to his work with ground squirrels in Tulare County, California in 1911, described this disease, and with a co-worker, Chaplin, isolated the causative agent of the disease and a year later named it *Bacterium tularensis*. Both Chaplin and a laboratory assistant had an obscure attack of fever while working on this problem and found later their blood serum agglutinated this organism. It was definitely proved by Francis in 1920 that the disease could be transmitted by an insect vector (Deer fly) by isolating the same organism from jack rabbits and several human cases of deer fly fever.

Tularemia has been reported in rodents in all states of the United States and in eleven geographically distributed foreign countries with the exception of the state of Vermont in the United States. There seems to be no seasonal preference except as it is influenced by insects or by contact with infected animals. Laboratory infections may occur at any time.

Animals susceptible to this disease are: cottontail rabbits, jack rabbits, snowshoe hare, ground squirrel, tree squirrel, coyote, fox, muskrat, opossum, deer, bull snake, groundhog, skunk, wild rat, field mouse, prairie dog, chipmunk, shrew and beaver. Natural infection has been found in some domestic animals such as sheep, hog, dog and cat. Domestic rabbits are susceptible to tularemia but as yet have only been infected in the laboratory. Horses and cows are apparently immune. It has been estimated that approximately one per cent of all wild rabbits are infected with tularemia.

Birds such as sage hen, quail, ruffed grouse and sharp tail grouse are naturally infected but the tularemia organism seems to be of lower virulence.

Wild rabbits are the main source of human infection, however, it should be emphasized that you can stay away from rabbits all your life and still contract this disease, as someone has estimated that ten percent of the total human infections are from other sources. Francis reports that there are at least twenty means by which man can acquire tularemia. Handling and dressing infected wild rabbits is the most common; other possibilities include insect bites, laboratory infections, ingestion, bites from infected animals and handling infected domestic animals.

The characteristic symptoms of the disease in rabbits is the appearance of sluggishness, stiffness and paralysis, even to the extent a child can outrun and catch a diseased wild cottontail. The pathology consists of enlarged lymph glands and coarse hair which is no longer soft and pleasant to the touch. The organisms affect all parts of the body of the animal, but concentrate primarily in the liver resulting in scar tissue which gives the liver a spotted appearance.

The incubation period in man varies from one to nine days with three days as the common length of time. The onset of the disease is very sudden and symptoms include headache, vomiting, fever, chills and aches and pains in various parts of the body. The infection develops at the point of entrance, and the associated lymph glands of the area become enlarged and painful. Several clinical types are reported in man. Mortality is approximately seven per cent. The disease persists for approximately three weeks with convalescence requiring from two to three months. Uncomplicated cases recover with no aftereffects and are followed by immunity against further exposure.

The recommended precautionary measures to take to prevent possible infection are; Use of rubber gloves when dressing and handling wild game, wild fowl and caring for laboratory animals. Wash hands thoroughly with soap and water and rinse in a good disinfectant solution. Always cook wild game well before eating. *Pasteurella tularensis* is easily killed by heat in ten minutes at 56°C to 58°C. Chemical disinfectants destroy the organism easily - tricresol 1.0 per cent in two minutes and formalin 0.1 per cent in twenty-four hours. Don't shoot a rabbit that appears weak or moves sluggishly, or if you prefer, kill it and bury with care to protect other hunters. With tularemia,



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as with other forms of disease, prevention is easier and certainly more pleasant than the cure.

The tularemia victim is one of the most fortunate beneficiaries of recent developments in the chemotherapy field, since dihydro-streptomycin has been discovered to be effective in most cases. However, there is some division of opinion in medical circles as to its value. Tularemia is not to be taken lightly. In spite of dihydro-streptomycin and other drugs, it can still be troublesome.

### References

Diseases Transmissible from Animal to Man - Hull

Rabbits and Tularemia (Radio Talk Nov. 29, 1951) John M. Gibson, Director, Division of Public Health Education, Alabama

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## PREVENTIVE MEDICINE

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To lose a pound of body fat by dieting is simple, but to lose the same pound by physical activity you would have to saw wood 10-1/2 hours, lay 14,731 bricks, do carpentry for 30 hours or shovel 114,000 pounds of sand. If you prefer athletics to manual labor, you may accomplish the same result by running 43 miles, wrestling for five and a half hours, playing football for close to five hours or doing freehand gymnastics for 10 hours. -- Max Millman, M.D., in Today's Health.

(The above is from Virginia Health Bulletin, State Dept. of Health, December 1951, Vol. 4, Series 2)

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### SAVING PREMATURE BABIES WELL WORTH THE STRUGGLE

The Washington Post recently published a cartoon in which a bouncing baby was pictured holding up two fingers in a V for victory and with a fat cigar in his mouth! The cartoonist knew very well that we would recognize this baby. What he possibly didn't know was that Winston Spencer Churchill had been not a bouncing baby but a tiny, weak, premature infant! Meticulous care pulled him through the perilous first year of his life and made it possible for him to become the vigorous, effective septuagenarian whom the free world salutes today as a great man.

Many of us have the notion that premature infants are never able to "catch up"; that if they survive at all, they are doomed to a life of sickness. The medical profession knows better. Doctors know that given the right environment, the premature has a good chance of survival and that after early childhood it is usually impossible to distinguish him either physically or mentally from his fullterm contemporaries. Indeed, with a fair start, he may eventually join the ranks of men of diverse genius who were once premature infants--Newton, Voltaire, Rousseau, Victor Hugo, Charles Darwin, Napoleon, George Bernard Shaw, and perhaps even St. Paul who tells us that he was "born out of due time".

(The above is from Conn. State Dept. of Health, Weekly Health Bulletin, 7 Jan 52)

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Attention is invited to provisions of revised AR 40-510, dated 4 Dec 51, "Medical Service-Dental Care," particularly those portions relating to Dental care by civilian dentists.



# CIVILIAN EMPLOYEES HEALTH SERVICE PROGRAM

DEPARTMENT OF DEFENSE, CIVILIAN EMPLOYEE HEALTH SERVICE DISPENSARY,  
MAIN NAVY BUILDING

By  
CLAYTON E. HILTS  
ADMINISTRATIVE OFFICER, CEHS



Among those attending opening ceremonies at Main Navy Dispensary were, left to right - Major General Paul H. Streit, Commanding General, Walter Reed Army Medical Center; Major General Thomas W. Herren, Commanding General, Military District of Washington; Dr. Joseph C. Smith, Chief Medical Officer, DD CEHS Dispensary, Main Navy Building; Colonel Robert E. Bitner, MC, Surgeon, Military District of Washington.

In July 1950, The Commanding General, Military District of Washington, requested that sufficient space be allocated in the Main Navy Building for the construction of an additional dispensary in the Civilian Employee Health Service program. After careful and thorough study of space requirements, an adequate area was made available on the second floor, in the fifth wing, consisting of 5700 square feet of floor space. Floor plans were then drafted for the layout of each section within the dispensary-treatment rooms, surgery, physical examinations, X-rays, laboratory, shock room, recovery bed section, physicians' offices, supply section and a nurses' dressing room. Related sections were planned to adjoin one another; the physical examination section and laboratory are adjacent to the X-ray section. All rooms are inter-connected so that a medical officer can complete one examination while a nurse performs the preliminary work on another individual. This allows for a continuous flow of physical examinees in or out of the section. Likewise, in the treatment section, the nurses and medical officer can greatly reduce the waiting time of the patients by this system.



## CIVILIAN EMPLOYEES HEALTH SERVICE PROGRAM

Public Building Service, GSA, was designated to perform necessary construction work. The Building Superintendent and members of his staff performed an excellent job, paying particular attention to the fine details of construction which made the result such an outstanding job.

The next step was the selection of functional and practical equipment for the type of medical services to be provided by the dispensary. All the equipment, except the X-ray finally chosen, is of the readily movable type. The combination sterilizer and autoclave is of the reservoir type which requires no plumbing attachments. When the equipment was finally selected, it was decided that all the equipment, medical and office, be contracted for in a single matching color. The shade chosen by the Department of the Navy was silver lustre.

Details for the coordination of procurement of all the new equipment were handled by the Medical Supply Office, Fort Myer, Virginia. Many difficulties were encountered due to the cut-back in steel production and priorities in procurement of the necessary equipment for the operation of the dispensary. The excellent co-operation of the Distribution Branch, Supply Division, Surgeon General's Office, Department of the Army, particularly the Domestic Section and the Supply Specialist, the co-operation of the Commanding Officer, Schenectady General Depot, in collaboration with the Medical Supply Staff at Fort Myer, made possible the expediting of the procurement of the necessary equipment.

The advice of the technical staff, Headquarters, Military District of Washington, was of great assistance in solving the many problems which arose and in arranging for technical support and services.

By the first of November 1951, the work was almost completed and sufficient equipment had arrived so that the date for the activation of the new dispensary could be set.

On 14 November 1951, Major General Thomas W. Herren, Commanding General, Military District of Washington, formally opened the new dispensary. Many dignitaries attended, including the Executive Officer to the Chairman, Armed Forces Policy Committee, Office of the Secretary of Defense; Director of Civil and Military Inter-relations Division, Office of the Secretary of Defense; representative, Office Secretary of the Army; representative, Office of the Secretary of the Air Force; The Inspector General, Bureau of Medicine and Surgery, Department of the Navy; Surgeon General, Department of the Army; Deputy Surgeon General, Air Force; representative for the Commandant, Potomac River Naval Command, Department of the Navy; Commanding General, Army Medical Center; Medical Director, Civil Service Commission; representative, Personnel Division, Department of the Army and Navy, and the Staff of the Commanding General, Military District of Washington.

This mission of this medical facility, as in the case of the other Department of Defense, Civilian Employee Health Service Dispensaries, in caring for the Department of Defense civilian personnel, is to keep the individual in the optimum of physical and mental health.

\* \* \* \* \*

TOO GOOD

A lot of the doctor's troubles, it seems to us, stem from a paradox: For a lot of real and practical purposes his reputation is too good. A lawyer may lose a case, and no one thinks anything of it. Indeed, it is understood that some lawyer will lose every case. A minister may lose a soul, but he usually gets credit for his good intentions. And a teacher may fail utterly to implant the fundamentals of learning with some dunderhead, but we readily concede that he did not have much to work with. Only with a doctor it is different. We expect him to perform miracles of medicine with the efficiency of a machine and without regard for the economic limitations which the rest of us find so binding upon our good intentions. And when, for any reason, he does not, may heaven have mercy upon him. No one else seems much inclined. The odd thing about this is that of all the professions medicine has made the most remarkable progress. Thanks alike to scientific discovery and the selfless devotion of the medical practitioner more people live longer in better health than ever before. The statistics prove it conclusively. In fact doctors have succeeded so well in reducing infant mortality and prolonging the life span that to many students of the world's problems over-population is, or ought to be, our chief concern. Strangely, when something goes wrong or seems to, a little of this is credited to the doctors' account. In part because of their collective record, we allow them no margin of error and impose a standard of perfection which we dare not apply to ourselves. It is at once a warm and honest compliment and a terrifying burden which we, as well as the doctors, might weight again. (W. Va. Med. J., Dec 1951, quoting Charleston Daily Mail - re-published in Indust. Med. & Surg, Jan 52)



GENERAL COMMENT

The health of the command continued to be excellent.

Unless otherwise indicated, reference to disease and injuries in this publication applies to all Class I and Class II installations, exclusive of Walter Reed Army Hospital. Rates are calculated on the basis of a thousand mean strength per year. Statistics presently reported by Army Medical Service installations do not include Air Force personnel. (See General Data and Admissions Tables on page 11).

The non-effective rate\* decreased from the November rate of 15.95 to 15.78 for the month of December. Days lost as a result of disease and injury totaled 13,299 during the four week period ending 26 December 1951.

\*Non-Effective Rate --  $\frac{\text{Total Days lost} \times 1,000}{\text{No. of Days in Period} \times \text{Average Daily Strength}}$

Non-Effective rates indicate the average number of patients in hospital or quarters per thousand mean strength during the report period.

The total admission rate\*\* for disease and injury in December was 330.4, compared to 338.5 during November. Total admissions for disease and injury in December was 763. Of this number 670 admissions were for disease and 93 injuries. All Others reported the highest admission rate, and the US Army Dispensary, The Pentagon reported the lowest rate during the current month.

\*\*Admission Rates --  $\frac{1,000 \times 365 \times \text{Number of Cases}}{\text{Mean Strength} \times \text{No. of Days in Period}}$

Admission rates show the number of cases per thousand strength that would occur during a year if cases occurred throughout the year at the same rate as in the report period.

December's rate for disease cases is 290.1 for 670 cases. All Others reported the highest admission rate, and Fort Belvoir reported the lowest rate for disease cases.

An injury admission rate of 40.2 per 1,000 per annum for December was reported. This was an increase over the November rate of 36.8. Fort Myer reported the highest rate and the US Army Dispensary, The Pentagon reported the lowest rate for injuries.

There were no deaths reported during the four week period ending 26 December 1951, by units within the Military District of Washington less Walter Reed Army Hospital.

COMMUNICABLE DISEASE

Common respiratory diseases increased in incidence during the month of December 1951. The rate for the present month is 115.6 compared to the November rate of 112.2. Fort Myer reported the highest rate, and Fort Belvoir reported the lowest rate. Admission rates for pneumonia (all types) decreased during the December report period. The rate being 6.9 compared with the November rate of 7.5. There were no cases of scarlet fever reported throughout the month of December.

No appreciable change was noted in the rate for mumps, tuberculosis, rheumatic fever, and hepatitis during the four week period ending 26 December 1951.

Pertinent statistical tables may be found on pages 11 and 16.



# PREVENTIVE MEDICINE

**RESTRICTED**  
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GENERAL DATA  
4-Week Period Ending 26 December 1951  
(Data from DD Forms 442)

STATION	MEAN STRENGTH			DIRECT ADMISSTONS						Non-Effective Rate	Number of Deaths
	Total	White	Negro	All Causes		Disease		Injuries			
				Cases	Rates	Cases	Rates	Cases	Rates		
Fort Belvoir, Virginia	18,357	16,235	2,122	392	278.35	335	237.88	57	40.47	16.37	0
Fort McNair, Wash, DC	916	844	72	23	327.30	20	284.61	3	42.69	6.67	0
Fort Myer, Virginia	3,968	3,807	161	139	456.62	118	387.63	21	68.99	10.56	0
US Army Dispensary The Pentagon	3,933	3,913	20	86	285.03	80	265.14	6	19.89	23.33	0
All Others	2,925	2,920	5	123	548.14	117	521.40	6	26.74	11.86	0
Total - Military Dist. of Washington	30,099	27,719	2,380	763	330.43	670	290.16	93	40.28	15.78	0
AMC - Med. Detach. (Duty Pers)	1,633	1,513	120	69	550.80	65	518.90	4	31.90	25.30	0

ADMISSIONS, SPECIFIED DISEASES - RATE PER 1000 PER YEAR  
4-Week Period Ending 26 December 1951  
(Data from DD Form 442)

STATION	Common Respiratory Diseases	Pneumonia All Types	Pneumonia Atypical	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Hepatitis	Malaria	Influenza	Psychiatric Disease
Fort Belvoir, Va.	93.02	6.39	4.97	5.68	-	-	-	-	1.42	-	-	2.84
Fort McNair, Wash, DC	170.76	-	-	-	-	-	-	-	-	-	-	14.23
Fort Myer, Virginia	193.82	3.29	-	-	-	-	-	-	-	3.29	-	3.29
US Army Dispensary The Pentagon	135.88	6.63	6.63	3.31	-	-	-	-	-	-	-	6.31
All Others	106.95	17.83	-	-	-	-	-	-	-	-	8.91	13.37
Total-Military Dist. of Washington	115.63	6.93	3.90	3.90	-	-	-	-	.87	.43	.87	4.33
AMC-Medical Detachment (Duty Personnel)	143.60	-	-	-	7.90	-	-	-	-	7.90	23.90	-

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**VENEREAL DISEASE**

Venereal Disease rate among units within the Military District of Washington, increased during the December report period.

The rate for December 1951, was 12.56 an increase over the November rate of 11.09. A total of 29 cases were reported for the four week period ending 26 December 1951. Of this total 26 were reported by Fort Belvoir, 2 cases for Fort McNair and 1 case for All Others.

During the report period, white personnel incurred 9 of the reported number of cases, with a rate of 4.23 and 20 were incurred by Negro personnel with a resulting rate of 109.54 per 1000 troops per annum.

In order to enable non-professional personnel to more intelligently understand the rates of cases to personnel on duty at each designated station, we have undertaken to report the number of cases per 1000 men for this report period (December) in addition to the rate per 1000 per annum which is not always clearly understood and is often misinterpreted.

Pertinent statistical tables and charts may be found on pages 12 and 13.

**NEW VENEREAL DISEASE CASES - EXCL EPTS - OCTOBER, NOVEMBER AND DECEMBER 1951**

STATION	Rate per 1000 per year	Rate per 1000 per year	Rate per 1000 per year	Cases per 1000 Troops
	OCTOBER 1951	NOVEMBER 1951	DECEMBER 1951	DECEMBER 1951
Fort Belvoir	25.43	16.72	18.46	1.416
Fort McNair	57.68	14.80	28.46	2.180
Fort Myer	10.86	3.35	-	-
US Army Dispensary, Pentagon	-	-	-	-
All Others	-	-	4.46	.342
Total - Military District of Washington Units	18.51	11.09	12.56	.963
Army Medical Center - Medical and Holding Detachments	13.07	28.21	20.22	1.550
Total - Dept/Army Units Military Dist/Wash	18.02	12.79	13.30	1.020



CHART 1

## ADMISSION RATES BY MONTH, ALL CAUSES, COMMON RESPIRATORY DISEASE AND INJURY MDW RATE PER 1000 TROOPS PER YEAR

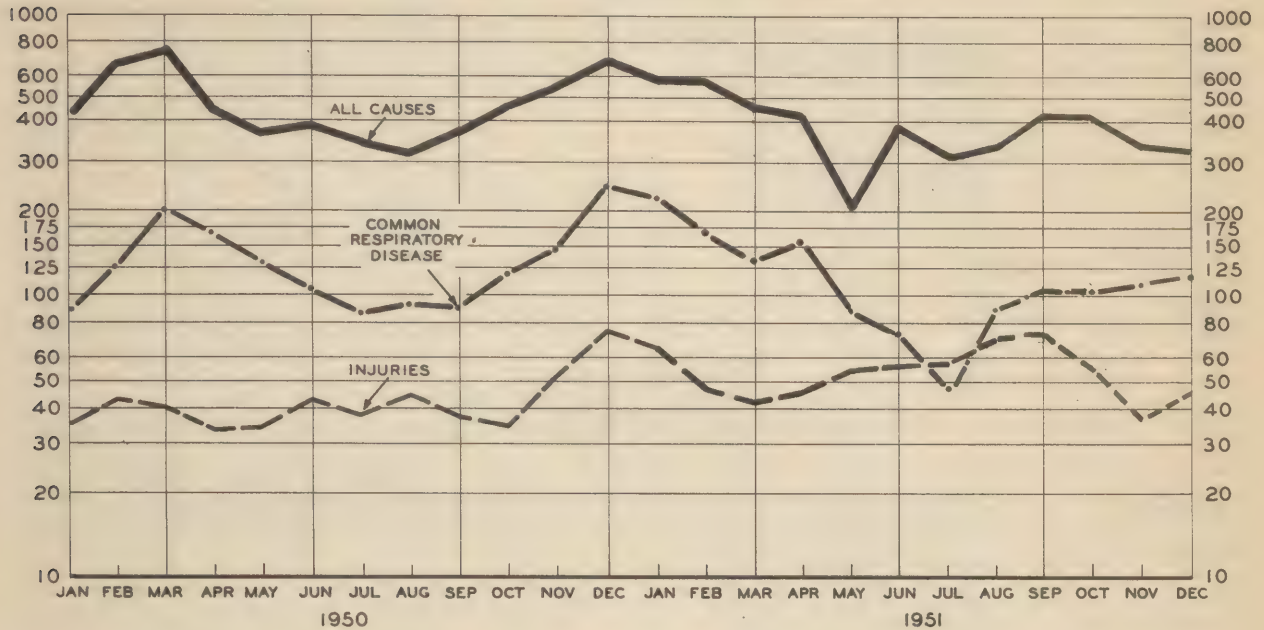
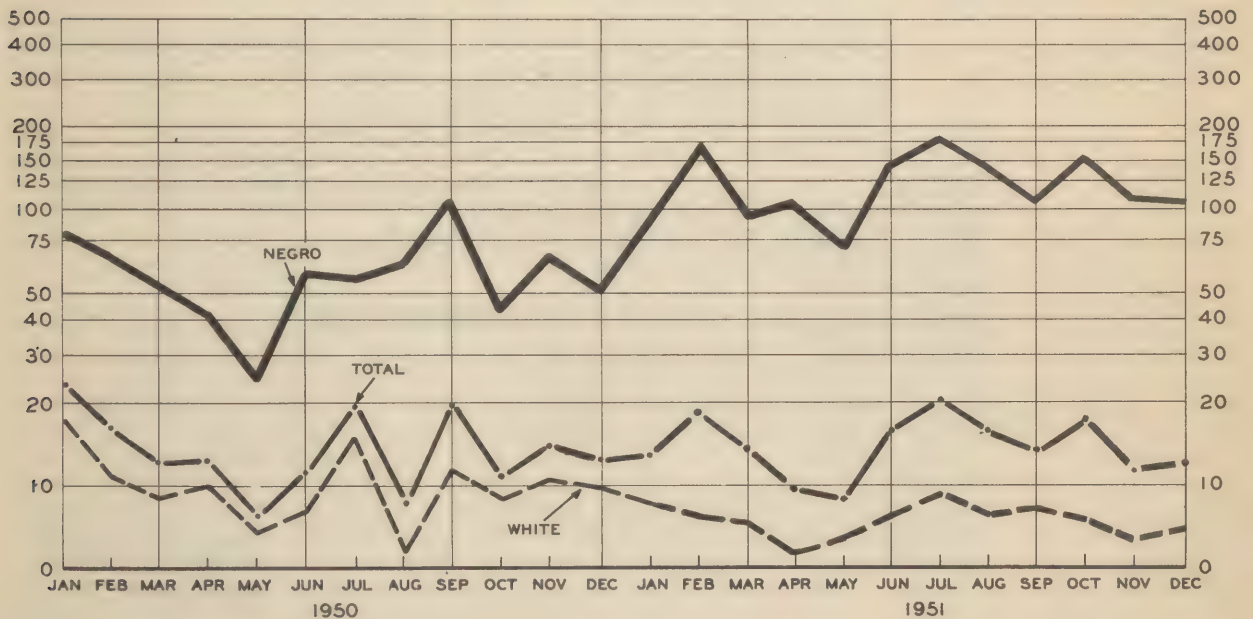


CHART 2

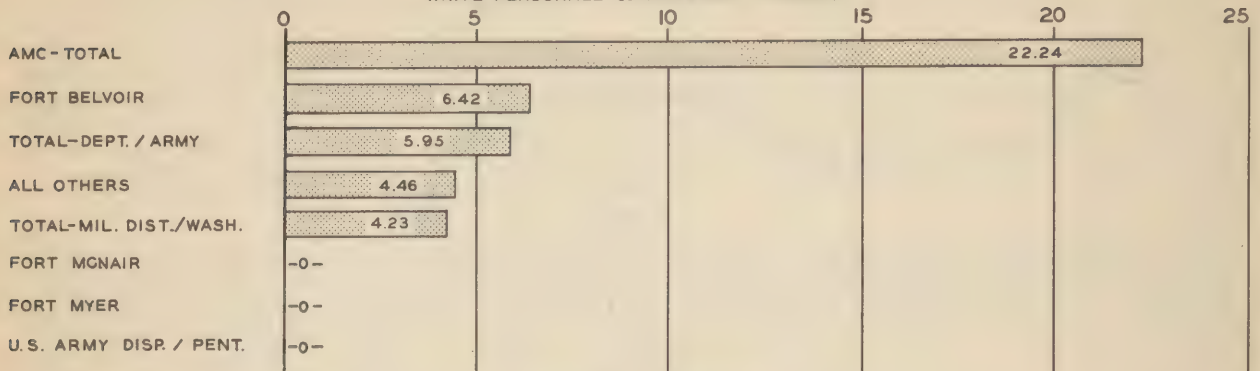
## ADMISSION RATES BY MONTH VENEREAL DISEASES MDW NOT INCL. ARMY MEDICAL CENTER RATES PER 1000 TROOPS PER YEAR INCLUDES ALL CASES REPORTED ON WD AGO 8-122 EXCEPTING THOSE EPTS



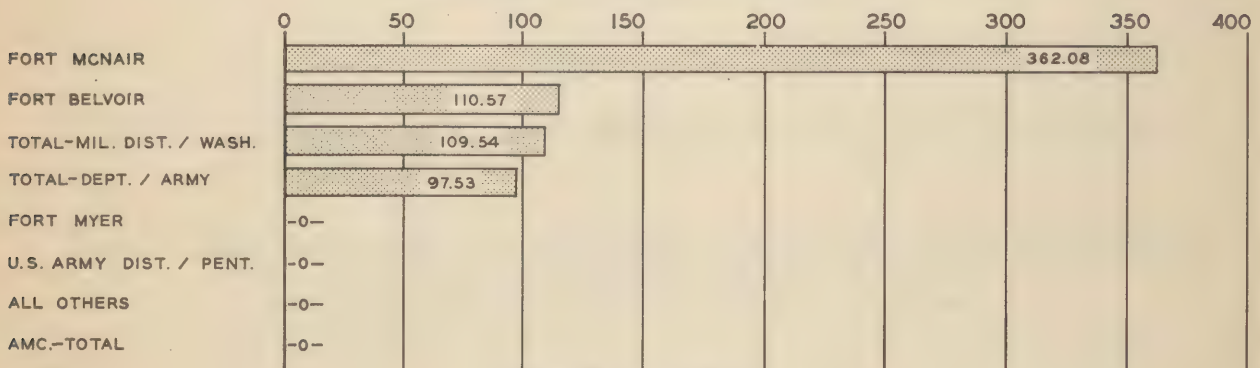


# PREVENTIVE MEDICINE

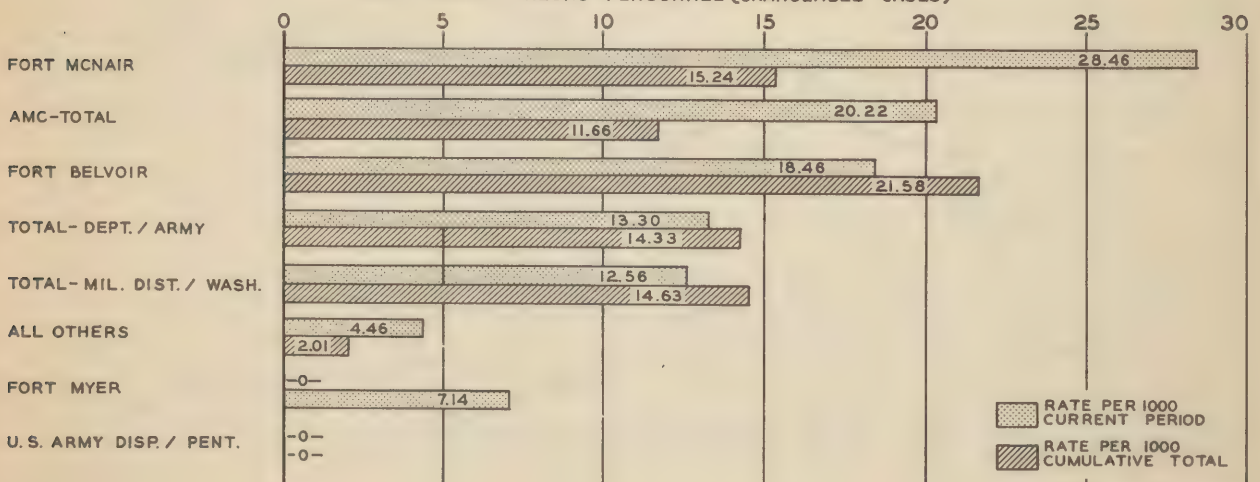
**VENEREAL DISEASE**  
RATE PER 1000 TROOPS PER YEAR  
4 WEEK PERIOD ENDING 26 DEC. 1951  
WHITE PERSONNEL (CHARGEABLE CASES)



**VENEREAL DISEASE**  
RATE PER 1000 TROOPS PER YEAR  
4 WEEK PERIOD ENDING 26 DEC. 1951  
NEGRO PERSONNEL (CHARGEABLE CASES)



**VENEREAL DISEASE**  
RATES PER 1000 PER YEAR  
FOUR WEEK & CUMULATIVE TOTALS ENDING 26 DEC. 1951  
TOTAL WHITE & NEGRO PERSONNEL (CHARGEABLE CASES)



RATE PER 1000 CURRENT PERIOD  
 RATE PER 1000 CUMULATIVE TOTAL



# PREVENTIVE MEDICINE

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## CONSOLIDATED MONTHLY VENEREAL DISEASE STATISTICAL REPORT For the Four Week Period Ending 26 December 1951 (Data from DD Form 442) (Chargeable Cases)

STATION	R A C E	Mean Strength	Syphilis	Gonorrhea	Other	Total	Rates per 1000 Troops per Annum
Fort Belvoir	W	16235	4	4	0	8	6.42
	N	2122	3	13	2	18	110.57
	T	18357	7	17	2	26	18.46
Fort McNair	W	844	0	0	0	0	-
	N	72	0	2	0	2	362.08
	T	916	0	2	0	2	28.46
Fort Myer	W	3807	0	0	0	0	-
	N	161	0	0	0	0	-
	T	3968	0	0	0	0	-
US Army Dispensary The Pentagon	W	3913	0	0	0	0	-
	N	20	0	0	0	0	-
	T	3933	0	0	0	0	-
All Others	W	2920	0	1	0	1	4.46
	N	5	0	0	0	0	-
	T	2925	0	1	0	1	4.46
Total-Military Dist. of Washington	W	27719	4	5	0	9	4.23
	N	2380	3	15	2	20	109.54
	T	30099	7	20	2	29	12.56
Army Medical Center	W	2931	4	1	0	5	22.24
	N	293	0	0	0	0	-
	T	3224	4	1	0	5	20.22
Total-Dept/Army Units	W	30650	8	6	0	14	5.95
	N	2673	3	15	2	20	97.53
	T	33323	11	21	2	34	13.30

### VENEREAL DISEASE RATES\* (All Army Troops)

	OCTOBER	NOVEMBER	DECEMBER
First Army Area	30	29	23
Second Army Area	26	27	21
Military District of Washington	18	13	14
Third Army Area	28	27	16
Fourth Army Area	33	36	27
Fifth Army Area	25	26	25
Sixth Army Area	42	37	36
TOTAL United States	30	29	23

\*Compiled in the Office of the Surgeon General and Includes US Army Hospitals.

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## DENTAL SERVICE

DENTAL SERVICE - FOUR WEEK PERIOD ENDING 26 DECEMBER 1951

STATION	Total Dentists		Sittings	Fillings	Bridges	Crowns	Dentures	Calculus Removed	Teeth Removed	Roentgenograms	Examinations
	Officer	Civilian									
Fort Belvoir	32	0	6379	3445	26	10	171	355	919	2137	3223
Fort McNair	2	0	363	275	2	1	24	11	53	136	78
Fort Myer	5	1	1510	388	2	3	29	146	83	177	528
US Army, Disp. Pentagon	9	0	1739	697	9	10	28	129	126	1022	1441
All Others	4	0	955	626	5	8	22	74	106	259	487
Total-MDW	52	1	10946	5431	44	32	274	715	1287	3731	5757

## VETERINARY SERVICE

POUNDS MEAT AND MEAT FOOD AND DAIRY PRODUCTS INSPECTED DECEMBER 1951  
(Data obtained from WD AGO Forms 8-134)

STATION	CLASS * 3	CLASS * 4	CLASS * 5	CLASS * 6	CLASS * 7	CLASS * 8	CLASS * 9	TOTAL
Fort Lesley J. McNair		93,143	117,971		223,742		53,936	488,792
Fort Belvoir, Virginia		814,908	358,268		1,120,938	174,197	575,624	3,043,935
Alexandria Field Buying Office		388,999	112,819	500,384			88,534	1,090,736
Fort Myer, Virginia		137,576	206,919		388,194	14,890	134,267	881,846
Cameron Station, Virginia		196,063	135,509		330,038	7,372	121,970	750,952
MDW Veterinary Detachment	786,013							786,013
The Pentagon						258,919		258,919
Army Medical Center		236,191	108,565		359,819		77,975	795,368
TOTAL	786,013	1,866,880	1,040,051	500,384	2,422,731	468,196	1,052,306	8,136,561

### REJECTIONS:

Insanitary or Unsound								
Fort McNair					160			160
Alex. Field Buying Off.		212						212
Mil Dist/Wash Vet Det	7,740							7,740
Fort Myer						500		500
The Pentagon						30		30
Army Medical Center		78				15		93
Not Type, Class or Grade								
Alex. Field Buying Off.		320						320
Mil Dist/Wash Vet Det	8,860							8,860
TOTAL	16,600	610			160	545		17,915

\*Class 3 - Prior to Purchase  
\*Class 4 - On delivery at Purchase  
\*Class 5 - Army Receipt except Purchase  
\*Class 6 - Prior to Shipment

\*Class 7 - At Issue  
\*Class 8 - Purchase by Post Exchange, Clubs  
Messes or Post Restaurants  
\*Class 9 - Storage

## OUTPATIENT SERVICE

### OUTPATIENT SERVICE

Consolidated statistical data on outpatient service, Military District of Washington, less Walter Reed Army Hospital, are indicated below for the four week period ending 26 December 1951:

#### ARMY:

Number of Outpatients . . . . . 11431  
Number of Treatments . . . . . 15372  
NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED . . . . .  
NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED . . . . .

#### NON-ARMY:

Number of Outpatients . . . . . 15225  
Number of Treatments . . . . . 17487  
NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED . . . . . 2915  
NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED . . . . . 18199

## HOSPITAL MESS ADMINISTRATION

### HOSPITAL MESS ADMINISTRATION

STATION	SEPTEMBER 1951	OCTOBER 1951	NOVEMBER 1951	DECEMBER 1951
Fort Belvoir				
Income per Ration	\$1.353	\$1.3222	\$1.3187	\$1.269
Expense per Ration	1.333	1.3335	1.2668	1.286
Gain or Loss	+.020	-.103	+.0519	-.017



# 1951 ANNUAL SUMMARY

## MDW HEALTH STATISTICS

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Communicable Diseases 1951 . . . . .	18
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Table - Specified Disease Rates . . . . .	19
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GENERAL SUMMARY 1951

Unless otherwise indicated, reference to disease and injuries in this summary applies to Class I and Class II installations exclusive of Walter Reed Army Hospital. Rates are calculated on the basis of a thousand man strength per year. Statistics presently reported by Army medical installations do not include Air Force personnel. (See page 19)

The annual non-effective rate was 15.30; this was an increase over the 13.14 rate of 1950. During the period the non-effective rate ranged from 12.89 in July to 16.94 in February. A total of 157,666 days lost were reported by units during 1951.

The non-effective rates for 1951 have been computed by charging to each unit the days lost in quarters, as well as days lost on hospital status by each member of their command.

Admissions for all causes during the year totaled 11768 with a resultant rate of 416.7. Of this total, 10280 with a rate of 364.0 for disease and 1488 with a rate of 52.7 for injury. Admissions for all causes during 1950 total 9151 with a resultant rate of 485.7. Disease accounted for 8318 cases with rate of 441.5 and injury 833 cases with a rate of 44.2. Fort Myer reported the highest rate of admissions with 595.9 per 1000 troops per year. The lowest rate 272.4 was reported by U. S. Army Dispensary, The Pentagon.

The incidence of injuries was 52.7 for 1951, compared to 44.2 cases per 1000 troops in 1950. Fort Myer reported the highest rate for injuries with 64.1 per 1000 troops per year. The lowest rate 17.4 was reported for U. S. Army Dispensary, The Pentagon. November had the lowest injuries rate with 36.8. The month of September had the highest rate with 71.8.

A total of 10280 cases of disease with a rate of 364.0 was reported in 1951. This may be compared to 8318 cases with a rate of 441.5 for 1950. Fort Myer reported the highest rate for disease with 531.8 per 1000 troops per year. The lowest rate 248.1 was reported by U. S. Army Dispensary, The Pentagon. During July the disease rate was lowest - 262.4, the highest rate was 531.3 in February.

Deaths among military personnel of Class I and II installations, exclusive of Walter Reed Army Hospital, totaled 21 during the year 1951.

COMMUNICABLE DISEASE

The annual rate of respiratory disease for 1951 was 111.7, compared to 127.2. The lowest rate was reported in July as 47.8. The month of January had the highest rate with 225.8.

An annual rate of 9.8 was recorded for a total of 277 cases of pneumonia all types. During 1950 there were 140 cases with a rate of 7.4. The highest rate was 19.1 for 51 cases reported in March, and the lowest was 3.9 for 11 cases reported in August.

The annual rate for measles was 14.0, mumps 4.1, tuberculosis 1.2, rheumatic fever 1.6, hepatitis .67 and malaria 1.9.

There were 3 cases of scarlet fever reported throughout the year 1951.

Pertinent statistical tables may be found on pages 19 and 22.

# 1951 PREVENTIVE MEDICINE 1952

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GENERAL DATA  
31 December 1950 to 30 December 1951  
(Data from DD Forms 442)

STATION	MEAN STRENGTH			DIRECT ADMISSIONS						Non-Effective Rate	Number of Deaths
	Total	White	Negro	All Causes		Disease		Injuries			
				Cases	Rates	Cases	Rates	Cases	Rates		
Fort Belvoir, Virginia	17010	15065	1945	7261	426.87	6186	363.67	1075	63.20	16.36	16
Fort McNair, Wash, DC	853	783	70	387	453.69	343	402.11	44	51.58	10.51	0
Fort Myer, Virginia	3930	3770	160	2342	595.93	2090	531.81	252	64.12	11.74	3
US Army Dispensary The Pentagon	3957	3935	22	1051	272.49	982	248.17	69	17.44	19.26	2
All Others	2486	2482	4	727	292.44	679	273.13	48	19.31	8.99	0
Total Military Dist. of Washington	28236	26035	2201	1178	416.77	10280	364.07	1488	52.70	15.30	21

ADMISSIONS, SPECIFIED DISEASES - RATE PER 1000 PER YEAR  
31 December 1950 to 30 December 1951  
(Data from DD Forms 442)

STATION	Common Respiratory Diseases	Pneumonia All Types	Pneumonia A typical	Influenza	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Hepatitis	Malaria	Psychiatric Disease
Fort Belvoir, Va.	94.18	13.58	9.99	1.12	18.81	4.35	.18	1.82	2.41	1.00	2.47	8.88
Fort McNair, Wash, DC	131.30	1.17	-	-	1.17	1.17	-	-	2.34	1.17	10.55	2.34
Fort Myer, Virginia	190.33	7.38	4.58	3.56	16.03	.76	-	.25	1.02	-	1.02	2.54
US Army Dispensary The Pentagon	128.38	2.78	2.27	-	2.27	1.77	-	.51	-	.25	.25	2.27
All Others	74.42	2.01	-	2.41	1.61	1.21	-	-	-	-	-	2.01
Total Military Dist. of Washington	11.74	9.81	6.98	1.38	14.06	4.12	.11	1.20	1.66	.67	1.98	6.27

HOSPITAL MEBS ADMINISTRATION  
(Data from WD AGO Form 8-210)

FORT BELVOIR - 1951

MONTH	INCOME PER RATION	EXPENSE PER RATION	GAIN OR LOSS PER RATION
January	\$1.1800	\$1.0200	+.1600
February	1.2200	1.1500	+.0700
March	1.2540	1.1350	+.1180
April	1.2999	1.2716	+.0283
May	1.2996	1.2549	+.0447
June	1.3178	1.2453	+.0725
July	1.3327	1.2586	+.0741
August	1.3455	1.2556	+.0900
September	1.3530	1.3330	+.0200
October	1.3232	1.3335	-.0103
November	1.3187	1.2668	+.0519
December	1.2690	1.2860	-.0170
Mean (Average 1951)	1.2927	1.2341	+.0586

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# 1951 PREVENTIVE MEDICINE 1952

## VENEREAL DISEASE-1951

Incidence of venereal disease for the entire year of 1951 among troops of the Military District of Washington, including Walter Reed Army Hospital, reflected a peak of 21 during the month of July with the low rate of 8 being reported in May. Through the remainder of the year the rate fluctuated between 8 and 21. With the exception of the month of July the Venereal Disease rate for the Military District of Washington was consistently below the consolidated rate for the continental United States.

Incidence of venereal disease for the Military District of Washington, less Walter Reed Army Hospital, was 14.59 for 1951, compared to 13.38 for 1950 and 17.41 for 1949. Fort Belvoir reported the highest rate with 21.58 and U. S. Army Dispensary, The Pentagon, the lowest with no cases reported.

Venereal disease incidence among white personnel fluctuated from a high of 8.21 during July to a low of 1.54 for April. Fort Belvoir reported the highest rate for white personnel with 7.37 and U. S. Army Dispensary, The Pentagon, the lowest with no cases reported. The white rate for 1951 was 5.45 compared to 9.24 during 1950, and 10.85 during 1949.

During the month of February the Negro incidence reached its highest rate of 171.43. The lowest rate was 73.81 reported in May. Fort McNair reported the highest rate with 185.71 and U. S. Army Dispensary, The Pentagon, the lowest with no cases reported. The Negro rate of 1951 was 122.67, compared to 56.88 during 1950, and 83.79 during 1949.

## VENEREAL DISEASE RATES FOR US - 1951\*

(All Army Troops)

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
First Army Area	19	11	10	11	15	21	31	39	42	30	29	23
Second Army Area	28	20	18	18	20	22	28	27	28	26	27	21
MDW	13	17	13	10	8	16	20	17	14	18	13	14
Third Army Area	36	22	21	20	19	30	32	26	26	28	27	16
Fourth Army Area	30	20	26	27	29	48	39	35	38	33	36	27
Fifth Army Area	14	11	10	15	17	19	24	28	29	25	26	25
Sixth Army Area	22	20	25	47	29	30	41	40	38	42	37	36
TOTAL US	25	18	19	22	21	28	32	31	32	30	29	23

\*This information compiled in Office of the Surgeon General and includes US Army Hospitals.

## OUTPATIENT SERVICE 1951

Consolidated statistical data on outpatient service, Military District of Washington, less Walter Reed Army Hospital, for the 52-week period ending 31 December 1951 are indicated below:

ARMY	NON-ARMY
Number of Outpatients . . . . . 135,265	Number of Outpatients . . . . . 162,619
Number of Treatments . . . . . 255,423	Number of Treatments . . . . . 261,461
NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED . . . . . 22,456	
NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED . . . . . 179,530	

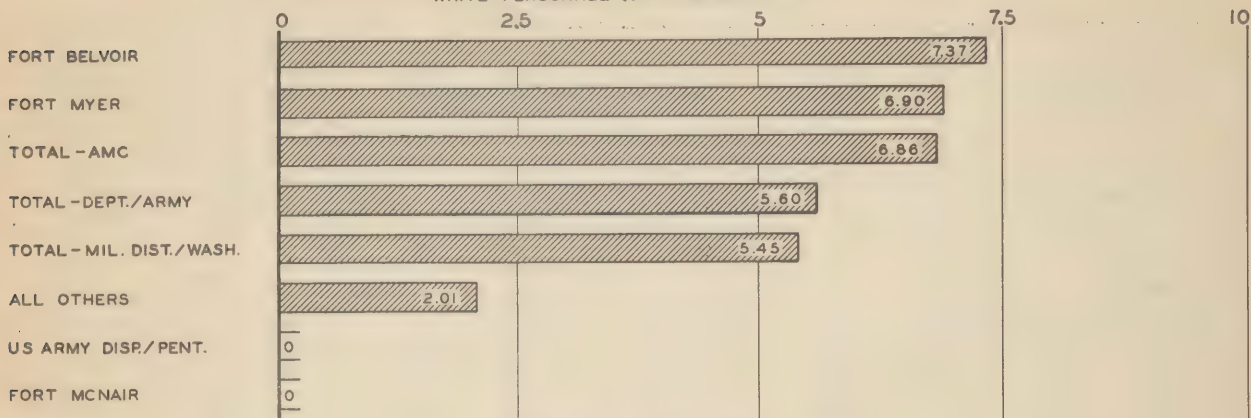
ANNUAL VENEREAL DISEASE STATISTICAL REPORT  
31 December 1950 to 30 December 1951  
(Data from DD Forms 442)(Chargeable Cases)

STATION	R A C E	Mean Strength	Syphilis	Gonorrhea	Other	Total	Rates per 1000 Troops per Annum
Fort Belvoir	W	15065	24	86	1	111	7.37
	N	1945	30	209	16	255	131.11
	T	17010	54	295	17	366	21.58
Fort McNair	W	783	0	0	0	0	-
	N	70	2	11	0	13	185.71
	T	853	2	11	0	13	15.24
Fort Myer	W	3770	4	21	1	26	6.90
	N	160	0	2	0	2	12.50
	T	3930	4	23	1	28	7.14
US Army Dispensary The Pentagon	W	3935	0	0	0	0	-
	N	22	0	0	0	0	-
	T	3957	0	0	0	0	-
All Others	W	2482	0	5	0	5	2.01
	N	4	0	0	0	0	-
	T	2486	0	5	0	5	2.01
Total-Military Dis- trict of Washington	W	26035	28	112	2	142	5.45
	N	2201	32	222	16	270	122.67
	T	28236	60	334	18	412	14.59
Army Medical Center	W	2914	18	2	0	20	6.86
	N	260	3	14	0	17	65.38
	T	2174	21	16	0	37	11.66
Total-Dept/Army Units	W	28949	46	174	2	162	5.60
	N	2461	35	236	16	287	116.62
	T	31410	81	350	18	449	10.84

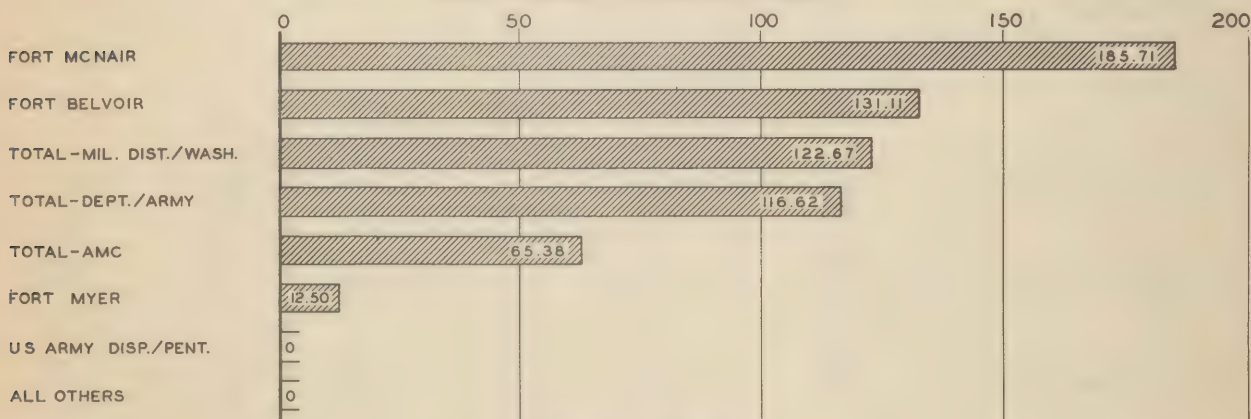


# 1951 PREVENTIVE MEDICINE 1952

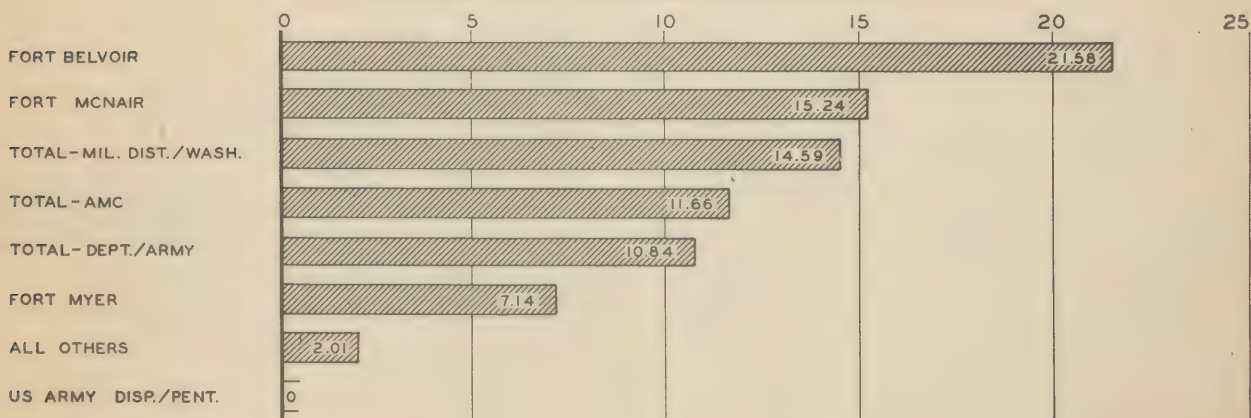
## VENEREAL DISEASE DISEASE RATE PER 1000 TROOPS PER YEAR 31 DECEMBER 1950 TO 30 DECEMBER 1951 WHITE PERSONNEL (CHARGEABLE CASES)



## VENEREAL DISEASE DISEASE RATE PER 1000 TROOPS PER YEAR 31 DECEMBER 1950 TO 30 DECEMBER 1951 NEGRO PERSONNEL (CHARGEABLE CASES)



## VENEREAL DISEASE DISEASE RATE PER 1000 TROOPS PER YEAR 31 DECEMBER 1950 TO 30 DECEMBER 1951 TOTAL WHITE & NEGRO PERSONNEL (CHARGEABLE CASES)



# 1951 DENTAL SERVICE 1952

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Security Information

DENTAL SERVICE - 52 WEEK PERIOD ENDING 31 DECEMBER 1951

STATION	Total Officer	Dentists Civilian	Sittings	Total Fillings	Bridges	Crowns	Dentures	Calculus Removed	Teeth Removed	Roentgen- ograms	Examinations
Fort Belvoir	27	1	81550	49684	204	173	1460	4589	18214	25852	31692
Fort McNair	2	0	4125	2834	14	9	132	241	446	2519	1150
Fort Myer	5	1	21436	8525	20	47	393	1402	1832	9653	5174
US Army, Disp. Pentagon	7	0	24933	9404	66	73	533	2262	1513	10088	10043
All Others	3	0	10784	5377	25	32	254	654	2164	2131	6203
Total - MDW	44	2	142828	75824	329	334	2772	9148	24169	50243	54262

# 1951 VETERINARY SERVICE 1952

CONSOLIDATED POUNDS MEAT, MEAT FOOD AND  
DAIRY PRODUCTS INSPECTED YEAR OF 1951

STATION	CLASS * 3	CLASS * 4	CLASS * 5	CLASS * 6	CLASS * 7	CLASS * 8	CLASS * 9	TOTAL
Fort Lesley J. McNair		801,128	1,714,714	4,517	2,536,834		772,094	5,829,287
Fort Belvoir, Virginia		8,279,625	4,456,438		12,563,700	1,840,451	5,187,334	32,332,548
Alexandria Field Buying Off.		6,813,091	2,108,495	8,927,692			1,370,568	19,219,846
Fort Myer, Virginia		1,848,686	2,200,815	1,268	4,089,350	135,759	1,667,728	9,943,606
Cameron Station, Alex., Va.		1,984,438	1,977,053	7,581	3,936,805	86,373	1,237,221	9,229,471
Mil. Dist/Wash Vet. Det.	9,871,121	58,500				3,888,570		9,929,621
The Pentagon						165,760	737,394	3,888,570
Walter Reed AMC		2,516,436	1,863,372		4,394,259			9,677,221
TOTAL	9,871,121	22,301,904	14,320,887	8,941,058	27,525,948	6,116,913	10,972,339	100,050,170

REJECTIONS:								
Insanitary or Unsound								
Fort McNair, Wash DC			53		662			715
Alex. Field Buying Off.		43,718		6			60	43,784
Fort Myer, Virginia						107		107
Cameron Station, Alex. Va.		144	53					197
Mil Dist/Wash, Vet Det	151,882							151,882
The Pentagon						30		30
Walter Reed AMC		78					15	93
Not type, class or grade								
Alex. Field Buying Off.		38,554						38,554
Fort Myer, Va.					99	599		698
Cameron Sta., Alex, Va.		406						406
Mil Dist/Wash, Vet Det	174,511	22,500						197,011
TOTAL	326,393	105,400	106	6	761	736	75	433,477

\*Class 3 - Prior to Purchase  
\*Class 4 - On delivery at Purchase  
\*Class 5 - Any Receipt except Purchase  
\*Class 6 - Prior to Shipment

\*Class 7 - At Issue  
\*Class 8 - Purchase by Post Exchange, Clubs,  
Messes or Post Restaurants  
\*Class 9 - Storage

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# 1951 CONSOLIDATED INDEX 1952

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Army Develops Perfect Substitute for Morphine	January	5
Army Expands Hospital Social Service Work	May	14
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Army Medical Service Sends Scrub Typhus Expedition to Malays	August	13
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Combat Exhaustion	November	1-5
Complete Text of VA Release on Rehabilitation of Korean Wounded	February	6
Conserving Physicians' Time	April	1
Control of Respiratory Disease	October	2
Dental Surgeon, MDW	December	1
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Determining and Recording of Blood Groups of all Military Personnel	August	7
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Dietitian as Mess Administrator	February	3
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Diseases of Animals Important to Man in Time of War	August	8-10
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Dry Ice, Exterminate Rodens with	December	11
Effect of the National Emergency on the Eligibility Requirements for Board Certification	July	9-11
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Epidemic Hemorrhagic Fever	December	10
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Establishment Inspection (Veterinary)	March	1-5
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Immediate Care and Follow-up of Burns in the Field	October	5
Importance of Medical Records and Reports	February	6
Improved Methods of Treating Frostbite	August	4
Indiscriminate Administration of Vitamins to Workers in Industry	January	18
Industrial Recommendations for Treatment of Fluoracetate Poisoning	January	4
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Interim Recommendations for Treatment of Fluoracetate Poisoning	September	6-7
International Certificate of Inoculation and Vaccination	February	1-2
Is Cancer Research Getting Anywhere	November	8
Jet Injection May Replace Needle	October	7
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Low Death Rate of Enemy Prisoners due to Army Medical Service Treatment	September	8-9
Man - The Most Important Weapon	May	13
Medical Company Commanders of Fixed Hospital	March	6-9
Medical Evaluation and the Gain in Illness	March	9-11
Medical Evaluation of the Non-Effective Soldier	January	3-4
Medical Evaluation of the Non-Effective Soldier	September	1-4
Medical Officers' Professional Training Record	December	2
Medical Personnel Win Outstanding Number of Decorations in Korea	September	9
Medical Supply Nonstandard Items and Services	October	11-12
Medical Technical Bulletins, Alphabetical Index	November	13-18
Neuropsychiatric Conditions in Korea, December 1950-March 1951	August	5
New Commanding Officer US Army Dispensary, Fort Myer, Virginia	October	1
New Commanding Officer of the US Army Hospital, Fort Belvoir, Virginia	January	6
New Drug Being Tested by Army May Provide Rapid Cure for Malaria	September	4
New Red Blood Cell Counter	October	12
New Time Saving Form for Handling of Quarters Cases	June	9
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Occupational Dermatitis, A Hazard to Industrial Workers	March	20
Our Educational Program for Corpsmen	December	4-5
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Parasites in Fish	October	14
Peace of Saline in Treatment of Injuries with Shock	October	3-5
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Premarital Examinations in Maryland, District of Columbia, and Virginia	May	11
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Report on "Q" Fever	June	4-7
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Rheumatic Fever	April	9
Shock Research Team	December	5
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Some Facts - Why Blood is Needed, How it is used	May	22
Some Probable Causes of Shortages in Weight in Frozen Milk Contracts	February	10
Some Tips on Conduct Overseas	January	9
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Support of Legal Dependents	May	14
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The Pentagon Prepares	December	3
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Trichinosis	November	19
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Utilization of stocks on hand	April	4
Veterinary Aspects of Atomic Energy	April	8-9
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X-Ray Diagnosis of Tuberculosis, Common Pitfalls in the	December	10